WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 21505

FILED JUN 23 1953

BIRTH NO. 278 84 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 2857

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City
c. LENGTH OF STAY (In this place): 2 mos
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2210 E. 8th St

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Jackson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City
d. STREET ADDRESS (If rural, give location): 2210 E. 8th St.

3. NAME OF DECEASED (Type or Print)
a. (First): RANDALL
b. (Middle): BILL
c. (Last): BUSCH

4. DATE OF DEATH (Month) (Day) (Year): June 7, 1953

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married
8. DATE OF BIRTH: December 2, 1952
9. AGE (In years last birthday): ~~6 mos~~ — If under 1 year: Months 6, Days 5, Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ---
10b. KIND OF BUSINESS OR INDUSTRY: ---
11. BIRTHPLACE (City and State or Foreign Country): St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY?: U. S.

13a. FATHER'S NAME: Billy O. Busch
13b. MOTHER'S MAIDEN NAME: Evadean Keltner
14. NAME OF HUSBAND OR WIFE: ---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: ---
17. INFORMANT'S SIGNATURE OR NAME: Mrs. Billy O. Busch — ADDRESS: K. C. Mo.

18. CAUSE OF DEATH — MEDICAL CERTIFICATION

Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Palsy — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: 334X

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): natural
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: Hugh H. Owens (Degree or Title): Deputy Coroner
23b. ADDRESS: 103 Realty Bldg.
23c. DATE SIGNED: 6-7-53

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 6/7/53
24c. NAME OF CEMETERY OR CREMATORY: —
24d. LOCATION (City, town, or county) (State): Springfeild, Mo.

DATE REC'D BY LOCAL REG.: 6-7-53
REGISTRAR'S SIGNATURE: Geraldine Smith
25. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Sheil Funeral Home — K. C. Mo.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

..... Student Embalmer No. .....

working under my personal supervision.

Student .....
Student Embalmer

Signed Richard E. Carroll.

Licensed Embalmer No. 4879

P. O. Address S. C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.